



LOW AIR-LOSS THERAPY SYSTEMS

All spaces **MUST** be completed by the Nursing Staff.

(All information must be current within 30 days of service dates. You must keep appropriate documentation to substantiate this information in your files.)

A current dated photo of the decubitus/decubiti must accompany this form.

CLIENT'S NAME		PIC NUMBER	
FACILITY NAME		TELEPHONE NUMBER	FAX NUMBER
RX PHYSICIAN		TELEPHONE NUMBER	FAX NUMBER
Diagnosis/Specific Disabilities: 			
PROGNOSIS/LIFE EXPECTANCY	PATIENT HEIGHT	WEIGHT	IDEAL BODY WEIGHT
Rate the following: <u>A</u> lways, <u>S</u> ometimes or <u>N</u> ever			
Mental/Behavioral: Alert: <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> N Oriented: <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> N Compliant with care: <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> N			
COMMENTS			
Medical Assistance Administration (MAA) policy states: The client's <u>medical condition requires them to be bed confined (20 hrs/day)</u> during rental of therapy system.			
How many hours/day is client in bed?		How many hours/day is client up in wheelchair?	
COMMENTS			
WOUND EVALUATION: (Must be current stage not "healing stage")			
	A.	B.	C.
Location			
Size			
Depth			
Stage			
Tunneling			
Drainage			

1. Turning & Repositioning Schedule:

2. List all medications:

3. List all treatments/dressings:

NUTRITIONAL/DIETARY STATUS

1. Fluid Intake:

2. Feeding:

a. Tube fed? <input type="checkbox"/> Yes <input type="checkbox"/> No	b. Self fed? <input type="checkbox"/> Yes <input type="checkbox"/> No With Assist? <input type="checkbox"/> Yes <input type="checkbox"/> No	c. Total daily calories?	d. Number of calories needed for healing:
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e. List all nutritional supplements given:

LABS

Date Drawn: _____

1. Albumin: _____ 2. Hematocrit: _____ 3. Hemoglobin: _____

ADDITIONAL COMMENTS:

If this request is for an extension beyond 3 months rental of the therapy system and there has not been a substantial improvement in wound status, please provide an explanation why including what changes in treatment are being implemented to improve healing potential.

NURSING STAFF SIGNATURE

DATE

TITLE